



Health Professions Quality Assurance
Nursing Commission
PO Box 1099
Olympia, WA 98507-1099

Certificate of Completion of LPN Program

(to be completed AFTER program completion)

I certify that the individual listed below **HAS** completed all requirements for the degree/diploma for the approved Licensed Practical Nurse program as outlined in WAC 246-840-5675. I understand that my signature on this form will allow this individual to sit for the practical nurse licensure examination. **An official transcript with the degree/diploma posted will follow as soon as it is available.**

LAST NAME OF GRADUATE	
FIRST NAME	MIDDLE NAME/INITIAL
DATE OF BIRTH	SOCIAL SECURITY NUMBER
DATE OF PROGRAM COMPLETION	

Signature of Authorized Person

Title

Name of School of Nursing

School

Seal

Dated this _____ day of _____, 2 _____

An Official Transcript is attached or will follow as soon as possible.

Please send completed form to:

Washington Nursing Commission
PO Box 1099
Olympia, WA 98507-1099